STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING _____ B. WING _____	C 04/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS HOUSE HEALTH & LIVING COMMUNITY	**300 J H WALKER DR PENDLETON, IN 46064**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This survey was for the Investigation of Complaint Number IN00147358. The visit was completed in conjunction with a Recertification and State Licensure Survey. Complaint IN00147358 - Substantiated, No deficiencies related to the allegation(s) are cited. Survey Dates: April, 7, 8, 9, 10, 11, 14, and 15, 2013 Facility number: 000248 Provider number: 155357 AIM number: 100291470 Survey team: Toni Maley, BSW, TC Ginger McNamee, RN Tina Smith-Staats, RN Karen Lewis, RN (4/7/14, 4/8/14) Census bed type: SNF/NF: 96 Residential: 54 Total: 150 Census payor type: Medicare: 23 Medicaid: 54 Other: 73 Total: 150 Sample: 3 Rawlins House was found to be in compliance with 42 CFR part 483 subpart B and IAC 16.2 in regard to the investigation of Complaint Number	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 IN00147358.	F 000		